# JOINT LEGISLATIVE OVERSIGHT COMMITTEE
# ON
# MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES


# REPORT TO THE 2008 REGULAR SESSION
# OF THE
# 2007 GENERAL ASSEMBLY

A LIMITED NUMBER OF COPIES OF THIS REPORT ARE AVAILABLE
FOR DISTRIBUTION THROUGH THE LEGISLATIVE LIBRARY

ROOMS 2126, 2226
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27611
TELEPHONE: (919) 733-7778

OR

ROOM 500
LEGISLATIVE OFFICE BUILDING
RALEIGH, NORTH CAROLINA 27603-5925
TELEPHONE: (919) 733-9390

THE REPORT IS ALSO AVAILABLE ONLINE:
http://www.ncleg.net/LegLibrary/

# TABLE OF CONTENTS

*JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES*
*State Legislative Building*
*Raleigh, North Carolina 27603*

*Senator Martin Nesbitt, Co-Chair* *Representative Verla Insko, Co-Chair*

# April 23, 2008

**TO THE MEMBERS OF THE 2007 GENERAL ASSEMBLY (2008 Regular Session):**

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services submits for your consideration its report pursuant to G.S. 120-231.

Respectfully Submitted,

| | |
|---|---|
| Sen. Martin Nesbitt, Co-Chair | Rep. Verla Insko, Co-Chair |

# JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES
## MEMBERSHIP LIST
## 2007- 2008

Senator Martin Nesbitt – Co-Chair
300-B Legislative Office Building
Raleigh, NC 27603
O: 715-3001 Email: Martinn@ncleg.net

Senator Austin Allran
516 Legislative Office Building
Raleigh, NC 27603
O: 733-5876 Email: Austina@ncleg.net

Senator Bob Atwater
312 Legislative Office Building
Raleigh, NC 27603
O: 715-3036 Email: Boba@ncleg.net

Senator Janet Cowell
1028 Legislative Building
Raleigh, NC 27601
O: 715-6400 Email: Janetc@ncleg.net

Senator Charlie Dannelly
2010 Legislative Building
Raleigh, NC 27601
O: 733-5955 Email: Charlied@ncleg.net

Senator James Forrester
1129 Legislative Building
Raleigh, NC 27601
O: 715-3050 Email: Jamesf@ncleg.net

Senator Vernon Malone
314 Legislative Office Building
Raleigh, NC 27603
O: 733-5880 Email: Vernonm@ncleg.net

Senator William Purcell
625 Legislative Office Building
Raleigh, NC 27603
O: 733-5953 Email: Williamp@ncleg.net

Senator Larry Shaw – Advisory Member
311 Legislative Office Building
Raleigh, NC 27603
O: 733-9349 Email: Larrys@ncleg.net

Representative Verla Insko – Co-Chair
2121 Legislative Building
Raleigh, NC 27601
O: 733-7208 Email: verlai@ncleg.net

Representative Martha Alexander
2208 Legislative Building
Raleigh, NC 27601
O: 733-5807 Email: Marthaa@ncleg.net

Representative Jeffrey Barnhart
608 Legislative Office Building
Raleigh, NC 27601
O: 715-2009 Email: Jeffba@ncleg.net

Representative Van Braxton: Advisory Member
403 Legislative Office Building
Raleigh, NC 27603
O: 715-3017 Email: Vanb@ncleg.net

Representative William Brisson: Advisory Member
1325 Legislative Building
Raleigh, NC 27601
O: 713-5772 Email: Williambr@ncleg.net

Representative Beverly Earle
634 Legislative Office Building
Raleigh, NC 27603
O: 715-2530 Email: Beverlye@ncleg.net

Representative Bob England
2219 Legislative Building
Raleigh, NC 27601
O: 733-5749 Email: Bobe@ncleg.net

Representative Jean Farmer-Butterfield
611 Legislative Office Building
Raleigh, NC 27603
O: 733-5898 Email: Jeanf@ncleg.net

Representative Carolyn Justus
1023 Legislative Building
Raleigh, NC 27601
O: 713-5956 Email: Carolynj@ncleg.net

Representative Fred Steen
514 Legislative Office Building
Raleigh, NC 27603
O: 733-5881 Email: Fredst@ncleg.net

## STAFF LIST

Rennie Hobby, Committee Assistant
O:733-5639
Email: mentalhealthca@ncleg.net

Gann Watson, Bill Drafting
O: 733-6660 Email: gannw@ncleg.net

Andrea Poole, Fiscal Research
O: 733-4910 Email: Andrear@ncleg.net

Denise Harb, Fiscal Research
O: 733-4910 Email: deniseha@ncleg.net

Shawn Parker, Research Division
O: 733-2578 Email: shawnp@ncleg.net

Ben Popkin, Research Division
O:733-2578 Email: benp@ncleg.net

Susan Barham, Research Division
O: 733-2578 Email: Susanb@ncleg.net

# PREFACE

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) is established in Article 27 of Chapter 120 of the General Statutes. The LOC is charged with continually examining system-wide issues that affect the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues related to governance, accountability and service quality.

The Committee consists of sixteen members, eight appointed by the President Pro Tempore of the Senate and eight appointed by the Speaker of the House of Representatives. The members appointed by the President Pro Tempore must include all of the following: at least two must be members of the Senate Committee on Appropriations, the Chair of the Senate Appropriations Committee on Human Resources and at least two must be of the minority party. The members appointed by the Speaker of the House must include all of the following: at least two members of the House Committee on Appropriations, the Co-Chairs of the House of Representatives Appropriations Subcommittee on Health and Human Services, and at least two members of the minority party. Advisory members may also serve on the Committee. The Co-Chairs for 2007-2008 are Senator Martin Nesbitt and Representative Verla Insko.

# COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services met 10 times during the 2007-2008 interim. Following is a summary of the Committee's proceedings. Detailed minutes and information from each Committee meeting are available in the Legislative Library.

**September 25, 2007**

The LOC convened its first meeting of the interim on Tuesday, September 25, 2007, at 10:00 A.M. in Room 643 of the Legislative Office Building. Senator Martin Nesbitt, Co-Chair, called the meeting to order and welcomed returning members, new members, and guests.

Dempsey Benton, Secretary of the Department of Health and Human Services (DHHS), presented DHHS priorities for improving the mental health system that included: implementation of the crisis services system, increasing provider capacity, enhancing substance abuse treatment facilities, and providing guidance and direction to the State hospitals.

Dr. Alice Lin, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH) consultant, presented her report on the *Implementation of Local Management Entities*. Dr. Lin discussed immediate, short-term, and mid-term recommendations.

Kory Goldsmith, Research Division, reviewed the process for the closure of Dorothea Dix and John Umstead Hospitals. According to Session Law 2007-323 Section 10.49.(t), the Secretary may close Dorothea Dix and John Umstead Hospitals provided certain conditions are met.

Jim Osberg, Chief of State Operated Services, DMH, discussed the closure plan for Dorothea Dix and John Umstead Hospitals pursuant to the opening of Central Regional Hospital (CRH) in Butner. Mr. Osberg provided a timeline for the design, construction, and operation of CRH.

Several updates were presented by staff concerning legislative actions from the 2007 Session. Andrea Poole, Fiscal Research Division, and Melanie Bush, Fiscal Research Division, provided a review of budgetary actions. Kory Goldsmith, Research Division, summarized substantive legislation enacted. Shawn Parker, Research Division, gave an update on Local Management Entities (LMEs) including historic and current LME configurations.

Trish Amend, NC Housing Finance Agency, and Julia Bick, DHHS, discussed the Housing 400 Initiative. Ms. Amend announced that financing for housing for persons with disabilities had been awarded for 425 units in 33 counties.

Jim Osberg, Chief of State Operated Services, DMH, provided an update to the LOC on the hospital utilization pilot. Mr. Osberg discussed the distribution of funding and the timeline for implementation of services to reduce utilization of State psychiatric hospitals.

Phillip Hoffman, Chief of Resource and Regulatory Management, DMH, reported on data collection of consumer income data. He also explained that DMH established a workgroup to examine the collection of county funds utilization data.

Bonnie Morrell, Team Leader for Best Practice, DMH, reported on crisis services implementation. In SFY 2006-2007, $7 million was expended for local inpatient services, facility based crisis, detoxification, and mobile crisis resulting in a decrease of admissions to the State psychiatric hospitals.

Flo Stein, Chief of Community Policy Management, DMH, discussed performance indicators. Ms. Stein reported LMEs that provided continuity of services saw significant improvement in mental health and substance abuse clients in every measurable indicator.

**October 31, 2007**

The LOC convened its second meeting of the interim on Wednesday, October 31, 2007, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Dr. Thomas McLellan, CEO of the Treatment Research Institute, discussed the State's role in the improvement of effectiveness and accountability for the treatment of addiction. Dr. McLellan explained the chronic care model in the treatment of addiction. Goals to measure success included: retaining patients at an appropriate level of care and monitoring, preparing patients to do well in the next level of care, and evaluating effectiveness during treatment instead of post-discharge.

Dr. Mandy Chalk, Director, Center for Performance Based Policy, Treatment Research Institute, provided information on funding treatment networks and contracting for substance abuse treatment services.

Kim Johnson, Network for the Improvement of Addiction Treatment, presented factors to consider regarding performance based contracting. Ms. Johnson suggested key elements to consider: a good data collection system, clear definitions for data elements, and agreed upon performance standards.

**November 15, 2007**

The LOC convened its third meeting of the interim on Thursday, November 15, 2007, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Andrea Poole, Fiscal Research Division, reviewed Section 10.49.(s1)-(s4) of Session Law 2007-323 regarding the hospital utilization pilot.

Laura White, Team Leader, State Psychiatric Hospitals, DMH, explained the selection process for the LMEs participating in the hospital utilization pilot.

Don Herring, Director of Service Management, Western Highlands Network, described plans for increasing crisis services and hospital diversion systems to decrease State hospital utilization.

Betty Taylor, CEO, CenterPoint Human Services, reviewed existing crisis services offered by CenterPoint and plans for expansion. Goals under the pilot included: reserving bed days for patients requiring longer stays, increasing enhanced psychiatric services, diverting clients from the legal system and the ER, and increasing adult transitional housing.

Tom McDevittt, LME Director, Smoky Mountain Center, presented a proposal to reduce hospital utilization by increasing local crisis services especially inpatient psychiatric beds through public/private partnerships with two hospitals in the area.

Tom Galligan, Deputy Director for Budget and Finance, Division of Medical Assistance (DMA), gave an update on community supports financial status. Mr. Galligan reported that approximately 45% of the 2007 budget for community supports was spent during the first 4 months of the fiscal year.

Leza Wainwright, Deputy Director, DMH, and Tara Larson, Acting Deputy Director for Clinical Affairs, DMA, gave an update on community support services. Ms. Wainwright and Ms. Larson provided background and reviewed the revised comprehensive plan that included clarification of service definitions, suspending new provider endorsements until new rules and provider qualifications are developed, monitoring and review of LMEs, and changing the authorization process.

Ms. Wainwright then presented an update on single stream funding and reviewed the criteria necessary for LMEs participation.

Next, Ms. Wainwright discussed the independent evaluation of LME performance. Ms. Wainwright explained that the Department contracted with Mercer Consulting for independent reviews to determine LME performance, possible consolidation of functions, and requirements for LMEs to perform utilization review.

Senator Nesbitt, Co-Chair, called on members of the audience for public comment.

**December 5, 2007**

The LOC convened its fourth meeting of the interim on Wednesday, December 5, 2007, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Grayce Crockett, Director, Mecklenburg Local Management Entity (LME), explained the Mecklenburg hospital utilization pilot to reduce bed days at Broughton hospital.

Tom Galligan, Deputy Director for Budget and Finance, Division of Medical Assistance (DMA), gave an update on community supports services.

Andrea Poole, Fiscal Research Division, reviewed the 2007-2008 FY LME service dollars allocation.

Leza Wainwright, Deputy Director, DMH, discussed the current allocation of community based services funds and explained the allocation of continuation funds.

Kory Goldsmith, Research Division, reviewed an information packet provided to committee members in response to questions from the previous meeting.

Mike Mosley, Director, DMH, and Leza Wainwright, Deputy Director, DMH, presented the revised plan for the closure of Dorothea Dix and John Umstead hospitals. Mr. Mosley reviewed the timeline for transition to the new hospital. Mr. Mosely also announced the development of an additional 60 bed unit on the Dorothea Dix campus.

Representative Insko, Co-Chair, called on members of the audience for public comment.

**January 23, 2008**

The LOC convened its fifth meeting of the interim on Wednesday, January 23, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Shawn Parker, Research Division, and Andrea Poole, Fiscal Research, reviewed an information packet provided to committee members in response to questions from the previous meeting.

Dempsey Benton, Secretary of the Department of Health and Human Services (DHHS), presented an update on the State psychiatric hospitals and community support services. Secretary Benton also discussed initiatives to establish committees of external experts to help with mental health issues.

Andrea Poole, Fiscal Research Division, and Denise Harb, Fiscal Research, reviewed a new report, the MH/DD/SA System Indicators report.

Shawn Parker, Research Division, provided background on the development of local crisis services plans.

Anthony Ward, Provider Relations Manager, Guilford Center, described the area's implementation of crisis services and discussed the successes and challenges of the implementation.

Art Constantini, Director, Southeastern Center for MH/DD/SAS, reviewed the crisis services in place at Southeastern Center. Mr. Constantini described the plan as continuum consisting of prevention measures, crisis response services, and post-crisis services.

Terry Hatcher, Director, Division of Property and Construction, DHHS, gave an update on construction projects.

Andrea Poole, Fiscal Research Division, reviewed Session Law 2007-323, Section 10.51(b) that directs DHHS to develop a revised service dollar allocation methodology to equalize funding to LMEs across the State.

Leza Wainwright, Deputy Director, discussed the revised service dollars allocation and explained a combination of two formulas was used to develop the methodology.

**February 27, 2008**

The LOC convened its sixth meeting of the interim on Wednesday, January 23, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Andrea Poole, Fiscal Research Division, reviewed an information packet provided in response to questions from the previous meeting. Next, Ms. Poole explained the monthly MH/DD/SA system indicators report and gave an update on construction projects.

Dan Coughlin, Area Director/CEO, Pam Shipman, Deputy Area Director, and Dr. Craig Hummel, Medical Director of Piedmont Behavioral Healthcare (PBH) discussed PBH's use of a 1915(b)/1915(c) combination Medicaid waiver. The waiver allowed PBH to restrict the freedom of choice of providers and to determine the size and scope of the provider network.

Gann Watson, Bill Drafting Division, explained the process for appealing a decision made by a State agency.

Emery Milliken, General Counsel, DHHS, provided information regarding the Medicaid appeals process, both formal and informal appeals.

Tara Larson, Deputy Director for Clinical Affairs, DMA, addressed the status of applications for additional Medicaid waivers. Ms. Larson highlighted options available through the waiver process with CMS. Leza Wainwright, Deputy Director, DMH, explained that DMH was working with LMEs to examine different waivers.

Flo Stein, Chief of Community Policy Management, DMH, presented an update on regionally funded and locally hosted substance abuse programs.

Leza Wainwright, Deputy Director, DMH, explained a technical amendment to the Community Alternatives Program (CAP) MR/DD waiver that allows family members or guardians to act as providers and provide personal care services to adult children.

Representative Insko, Co-Chair, called on members of the audience for public comment.

**February 28, 2008**

The LOC convened its seventh meeting of the interim on Thursday, February 28, 2008, at 9:00 A.M. in Room 643 of the Legislative Office Building.

As a follow-up on the appeals process, Representative Insko, Co-Chair, welcomed Judge Julian Mann, Director and Chief Administrative Law Judge of the Office of Administrative Hearings (OAH). Administrative Law Judge Don Overby, and Chief Clerk, Kim Housing were also in attendance. Judge Mann provided an overview of the OAH and addressed questions regarding the impact

of the community support appeals cases on the OAH. Judge Mann suggested that for cases that are *pro se*, the State file instead of the petitioner and that pre trial motions that interfere with getting to the merit of the case be eliminated.

Representative Insko asked Vicky Smith, Executive Director of Disabilities Rights of North Carolina, to respond to comments. Ms. Smith suggested that a clearly articulated, easily understood bill of rights for people with disabilities receiving services was needed whether the services were federally funded or State funded.

Next, Phillip Hoffman, Chief of Resources/Regulatory Management, DMH, gave an update on data collection and county funds utilization. He explained that DMH's reporting requirements were modified to include information on family size. Currently, the amount of county funds budgeted and received through the LMEs is reported but not how the funds are utilized.

Flo Stein, Chief of Community Policy Management, DMH, gave a presentation on crisis services for the developmentally disabled. Ms. Stein described barriers to receiving service and explained the importance of a functional assessment, training, and technical assistance. She explained several proven models in detail. Ms. Stein stated that DMH recommended that the Systematic Therapeutic Assessment Respite and Treatment (START) Program be implemented on a regional basis.

Next, Carol Donin, Developmental Center Team Leader, DMH, addressed downsizing at the developmental centers. Ms. Donin reported that most consumers moved to community residential settings such as Intermediate Care Facilities (ICF/MR) group homes and live-in group homes supported by the Community Alternatives Program (CAP) MR/DD waiver. Ms. Donin also mentioned the ICF-MR bed transfer initiative.

Tara Larson, Acting Deputy Director of Clinical Affairs, DMA, addressed cost-sharing under CAP. She explained that the Department looking at families currently on the CAP/MR and CAP/C waiver programs and developing a process by which families would pay for part of their care.

Rose Burnette, Tiered Waiver Project Manager, DMH, gave an update on the CAP-MR/DD waiver development. She explained that DHHS requested an extension from CMS to develop the four tiered waivers and projected implementation for the tiered waivers between January and June 2009.

Andrea Poole, Fiscal Research, reviewed a draft of recommendation options with committee members.

**March 26, 2008**

The LOC convened its eighth meeting of the interim on Wednesday, March 26, 2008, at 9:00 A.M. in Room 643 of the Legislative Office Building.

Shawn Parker, Research Division, reviewed an information packet provided to committee members in response to questions from the previous meeting.

Denise Harb and Andrea Poole, Fiscal Research Division, reviewed the monthly MH/DD/SA system indicators report.

Roman Rojano, Area Director, Wake County Human Services presented short and long term initiatives that addressed the closure of Dorothea Dix hospital.

Sharen Prevatte, Area Director, Southeastern Regional MH/DD/SA Services, discussed the status of the LME. Ms. Prevatte explained that Southeastern Regional utilized a combination of inpatient services at area hospitals, a mobile crisis team, a local crisis stabilization facility, and psychiatrists.

Andrea Poole, Fiscal Research Division, and Shawn Parker, Research Division, presented draft findings and recommendations to the LOC.

Trish Amend, NC Housing Finance Agency, and Julia Bick, DHHS, discussed the Housing 400 Initiative. Ms. Amend announced that over 1,300 units had been funded, 681 units completed, and 604 of those units were occupied.

Bonnie Morrell, Team Leader for Best Practice, DMH, gave a presentation on transitional residential treatment options for housing individuals with mental illness in the community.

Tara Larson, Acting Deputy Director for Clinical Affairs, DMA, explained issues surrounding the suspension of Medicaid eligibility for individuals in State institutions.

Denise Harb, Fiscal Research Division, and Gann Watson, Bill Drafting Division, continued the presentation of draft findings and recommendations to the committee members and incorporated proposals from members of the committee.

Dempsey Benton, Secretary of the Department of Health and Human Services, presented a report on the Department's recommendations.

**April 17, 2008**

The LOC convened its ninth meeting of the interim on Wednesday, April 17, 2008, at 9:00 A.M. in Room 544 of the Legislative Office Building.

Mike Watson, CEO, Sandhills Center for MH/DD/SAS, discussed single stream initiatives and hospital transition teams at Sandhills.

Roy Wilson, CEO, East Carolina Behavioral Health (ECBH), gave an overview of services at ECBH and explained that quality services are based on consumers' needs.

Tara Larson, Acting Deputy Director for Clinical Affairs, DMA, presented background on the Workforce Development Initiative. Ms. Larson then introduced John Morris, Annapolis Coalition on the Behavioral Health Workforce, and Dr. Amy Hewitt, University of Minnesota, Institute on Community Integrations.

Mr. Morris discussed goals and strategies for strengthening and supporting the workforce in the areas of behavioral health, developmental disabilities, and aging.

Dr. Hewitt, provided an overview of the direct support workforce in North Carolina and identified strategies to build systems that maximize support and development of direct support workers.

Leza Wainwright, Co-Director, Division of MH/DD/SAS, presented the findings and recommendations from the *Independent Evaluation of the Performance of Local Management Entities* report by Mercer.

Dempsey Benton, Secretary, Department of Health and Human Services (DHHS), announced priorities for DHHS including funding for additional staff at the State psychiatric hospitals, establishment of a statewide network of mobile crisis teams, procurement of additional community inpatient beds, and the voluntary development of regional LMEs.

Representative Insko, Co-Chair, called on members of the audience for public comment.

After lunch the LOC reconvened in Room 643 of the Legislative Office Building and Representative Insko, continued the public comment period.

Steve Hairston, Chief of Operations Support, DMH, reported on the Workforce Development Initiative.

Dr. Marvin Swartz, Chair, Commission for MH/DD/SAS presented an overview and the recommendations for the MH/DD/SAS Workforce Plan.

Pam Silberman, President/CEO, North Carolina Institute of Medicine, discussed the Substance Abuse Task Force draft findings and recommendations.

Andrea Poole, Fiscal Research, reviewed changes to the LOC draft report and incorporated proposals from members of the committee.

Gann Watson, Bill Drafting Division, explained the bill draft containing the LOC recommendations.

**April 23, 2008**

The LOC convened its tenth meeting of the interim on Wednesday, April 23, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Representative Insko, Co-Chair, called on members of the audience for public comment.

Denise Harb and Andrea Poole, Fiscal Research Division, reviewed the monthly MH/DD/SA system indicators report.

Tara Larson, Acting Deputy Director for Clinical Affairs, Division of Medical Assistance (DMA), presented DMA's plans to renew the contract with ValueOptions for utilization review services and answered questions from the LOC regarding the contract.

Andrea Poole, Fiscal Research Division, reviewed changes to the draft report and Gann Watson, Bill Drafting Division, explained changes to the bill draft

containing the LOC recommendations. After discussion, the LOC approved the bill with some modifications and moved to include it in the LOC report.

Representative Insko, Co-Chair, offered a joint resolution to authorize the Legislative Research Commission to study the involuntary commitment statutes in Chapter 122C of the General Statutes. The LOC approved the joint resolution and voted to include it in the LOC Report.

Senator Nesbitt, Co-Chair, made the motion that the report be approved as amended and instructed staff to make technical and conforming changes as necessary. The motion was approved by the LOC.

# COMMITTEE FINDINGS AND RECOMMENDATIONS

## INTRODUCTION

The LOC – and more recently the Department of Health and Human Services and the press – has identified problems concerning the administration of mental health, developmental disabilities, and substance abuse services at the State and local levels. Some of these problems and issues can be addressed in the 2008 Regular Session of the 2007 General Assembly. Others will require more review and scrutiny, and thus more time to identify and implement significant, long-term changes in the system at all levels of administration.

As a backdrop for the recommendations and legislative proposals contained in this report, it is important to understand the historical context and the fundamental policy behind MH/DD/SA System Reform enacted by the 2001 General Assembly in House Bill 381 and amendments enacted since that time.

During the mid to late-1990's, North Carolina's public system for delivering services to those with mental illness, developmental disabilities, and substance abuse addictions faced significant challenges. Several local agencies were in imminent danger of financial collapse and the State-run psychiatric hospitals were threatened with the loss of federal funding due to inadequate staffing and record-keeping violations. During this same period, the United States Supreme Court held that States have an obligation to provide community-based treatment for persons with mental disabilities when: (i) State medical professionals determine community placement is appropriate; (ii) placement would be less restrictive and is not opposed by the patient; and (iii) community placement can be reasonably accommodated, given resources available to the State and the needs of others with mental disabilities.[1] In response to these challenges, the General Assembly commissioned a series of studies and created the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) to make recommendations as to what should be done.

Policy enacted in Session Law 2001-487[2] set the framework for system reform. Specifically, it made significant changes addressing issues of State and local

[1] Olmstead v. L.C., 527 U.S. 581 (1999); Title II of the Americans with Disabilities Act.
[2] HB 381 - An Act to Phase in the Implementation of Mental Health System Reform at the State and Local Level (S.L. 2001-437).

governance and increased accountability. The act emphasized consumer-driven community-based services. It required that State and local governments provide certain core services to all individuals and required the development of enhanced services that targeted persons with the most severe disabilities. In addition, the act shifted the role of local public mental health agencies from being direct service providers to managing and coordinating services delivered by private providers. [3]

**Policy of the State**

"*The policy of the State is to assist individuals with needs for mental health, developmental disabilities, and substance abuse services in ways consistent with the dignity, rights, and responsibilities of all North Carolina citizens. Within available resources it is the obligation of State and local government to provide mental health, developmental disabilities, and substance abuse services through a delivery system designed to meet the needs of clients in the least restrictive, therapeutically most appropriate setting available and to maximize their quality of life…..State and local governments shall develop and maintain a unified system of services centered in area authorities or county programs. The public service system will strive to provide a continuum of services for clients while considering the availability of services in the private sector…*".[4]

**Administration of the System**

"*The Secretary shall administer and enforce the provisions of this Chapter and the rules of the Commission and shall operate State facilities. An area director or program director shall (i) manage the public mental health, developmental disabilities, and substance abuse services system for the area authority or county program according to the local business plan, and (ii) enforce applicable State laws, rules of the Commission, and rules of the Secretary. The Secretary in cooperation with area and county program directors and State facility directors shall provide for the coordination of public services between area authorities, county programs, and State facilities…*".[5]

"*Local management entities are responsible for the management and oversight of the public system of Mental Health, Developmental Disabilities, and Substance Abuse Services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.*"[6]

---

[3] N.C. Legislative Services Office, Research Division. *System Reform for Mental Health, Developmental Disabilities, and Substance Abuse Services.* 1 INFO BRIEF, no. 2 (Oct. 10, 2006).

[4] N.C.G.S. §122C-2

[5] N.C.G.S. §122C-111

[6] N.C.G.S. §122C-115.4

**Systemwide Accountability**

*"Every county, through an area authority or county program, shall provide for the development, review, and approval of an LME business plan for the management and delivery of mental health, developmental disabilities, and substance abuse services."*[7]

*If an LME is not providing minimally adequate services the law authorizes the Secretary of DHHS to take certain actions after notice and time for correction by the LME. Those actions include suspension of funding, appointing a caretaker administrator or caretaker board of directors, and termination of an area director of program director when the Secretary appoints a caretaker administrator.*[8]

*Upon a determination by the Secretary that an area authority or county program is in imminent danger of failing financially and of failing to provide direct services to clients, the Secretary may assume control of the financial affairs of the area authority or county program and appoint an administrator to exercise the power assumed*[9].

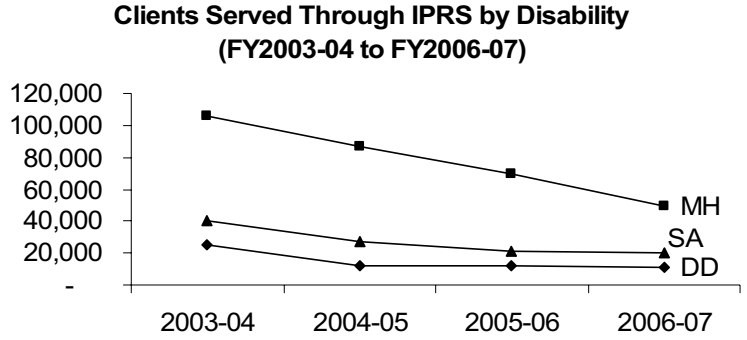
In light of the issues that have emerged regarding the implementation and administration of MH/DD/SA system reform, the LOC respectfully reports the following findings and recommendations for consideration by the 2007 General Assembly, Regular Session, 2008. The legislative proposal can be found in the Appendix to this report.

[7] N.C.G.S §122C-115.2
[8] N.C.G.S. §122C-124.1.
[9] N.C.G.S. §122C-125

## FINDING ONE: EXPENDITURE OF SERVICE DOLLARS

State funds appropriated for services are not being fully expended for the intended purpose, especially in the areas of crisis services and substance abuse services. For example, in FY 2006-07, $47.7 million in State service dollars was unexpended. Of that, the 2007 General Assembly realigned $26.4 million for FY 2007-08 and the remaining funds were earmarked for LME systems administration for FY 2007-08. In FY 2007-08, it appears that service dollars will again be under-expended – particularly State funding for crisis services and substance abuse services.

Since FY 2003-04, the State has served fewer clients each year through the State IPRS system, the claims processing system for State-paid clients. The State served half as many clients in FY 2006-07 as it did in FY 2003-04[10]. The decline in clients served is particularly high for individuals with mental health and substance abuse services needs, as is shown in the chart below. While there was a corresponding increase in the number of persons with mental health needs served through Medicaid, more research is needed to determine if those services are reaching the same population that State-paid services are designed to help.




Additionally, there have anecdotal reports that providers are increasingly unwilling to provide services to State-paid clients and prefer to provide services to Medicaid-paid clients. A preliminarily review of available data suggests that this may be the case.

There are conflicting explanations available for the under-expenditure of funds, the decrease in services to State-paid individuals, and the lack of service providers available to treat State-paid clients. However, despite hearing from and meeting

[10] Measuring Trends in Public MHDDSA Payments and Persons Served, Medicaid and IPRS Aggregate Utilization Data by LME as presented at FARO in November, 2007: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

with LMEs, providers, and DHHS, the LOC has not been able to determine a full explanation of the problem.

Given the increased needs for these services seen in the community, the jails, State hospitals, and emergency rooms, it is vital that these funds are spent appropriately and that within those available resources, services be made available to individuals who do not qualify for Medicaid.

## RECOMMENDATION ONE:

1. Adjust the timing and method by which each non-single-stream LME's services dollar allocations are distributed, in order to mitigate cash-flow problems that many LMEs experience at the beginning of the fiscal year. Specifically, distribute no less than one-twelfth of each non-single-stream LME's allocation to the respective LME at the beginning of the fiscal year, and subtract this amount from the LME's total reimbursements for the fiscal year.

2. Appropriate $6 million for DHHS to establish additional regionally-purchased and locally-hosted substance abuse programs.

3. Encourage the conversion of the remaining non-single-stream LMEs to single-stream funding as soon as possible.

   Appropriate to DHHS $675,000 for technical assistance to those LMEs not currently meeting the standards necessary for single-stream funding.

   Direct DHHS to develop standards for the removal of single-stream designation for those LMEs that do not continue to meet the single-stream standards once designated.

4. Direct DHHS to simplify the current State Integrated Payment and Reporting System (IPRS) to encourage more providers to serve State-paid clients.

5. Direct DHHS to create a reporting system for both single-stream funding and non-unit-cost-reimbursement funding that is readily comprehensible and integrates with payment systems.

6. Direct DHHS, in consultation with LMEs and providers, to determine why there have been over- and under-expenditures of State service dollars by LMEs and to take the actions necessary to address the

problem. Also direct DHHS to report to the General Assembly no later than January 1, 2009 on the actions taken.

7. Appropriate $1 million to the General Assembly to be used to retain the services of an independent consultant to perform a services gap analysis of the Mental Health, Developmental Disabilities, and Substance Abuse Services System. The RFP should require the Independent Consultant to report its findings and recommendations by May 1, 2009.

   Also, recommend that the Joint Legislative Program Evaluation Oversight Committee include in the work plan for the Program Evaluation Division a thorough performance evaluation of the State's mental health agencies in the Department of Health and Human Services (the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Division of Medical Assistance) to be completed by May 1, 2009.

## FINDING TWO: STATE-OPERATED SERVICES

The State psychiatric hospitals are admitting more clients than in prior years – approximately 2,600 more admissions in FY 2006-07 than in FY 2002-03.

In January 2007, due to increased admissions to the hospitals' acute units (particularly the adult acute units), the Department of Health and Human Services put a delayed admissions policy into effect: when a State psychiatric hospitals' acute units reach 110% capacity, no admissions are accepted until those units are once again below 110% capacity.

Three hospitals (Dix, Umstead, and Broughton) have been on delayed status[11]. The chart below shows the percent of days that each of those three hospitals have been on delayed status in the portion of FY 2006-07 that the policy was in effect and in FY 2007-08 as of February 2008. Broughton and Dix each have been at or above 110% capacity – and thus on delayed status – more than half the time.

| Percent of Days on Delayed Status | | | |
|---|---|---|---|
| | **Broughton** | **Dix** | **Umstead** |
| **January 2007 - June 2007** | 65% | 49% | 22% |
| **July 2007 - February 2008** | 71% | 59% | 31% |

Additionally, during SFY 2007-08, due in part to the absence of qualified permanent staff, State psychiatric hospitals were in jeopardy of losing their certification by the federal Centers for Medicaid and Medicare Services (CMS), and Broughton hospital did lose certification.

A hospital without CMS certification cannot bill Medicaid or Medicare for services, increasing the portion of the cost of hospital services that must be paid for by the State. Moreover, a non-certified hospital diminishes public confidence in our mental health system. The services and administrative practices at the State psychiatric hospitals need to be improved, to meet federal and State standards and to restore the public confidence. State institutions need the ability to hire and retain high-quality staff.

[11]As of February 2008, Cherry Hospital has not been on delayed status – the hospital has been over capacity, but has been able to divert referrals rather than delay admissions.

It is the policy of the State that the State hospitals be used only as a last resort: to be used for those individuals whose level of acuity prevents them from being served adequately by community service providers and for those individuals who local hospitals are unable to admit[12]. In the short-term, the increased demand for State hospital admissions needs be met to ensure the availability of that level of care when it is needed. However, this short-term increase in availability should not undermine the system's commitment to the previously stated policy. In the long-term, the demand needs to be reduced by providing alternative services in the community for individuals in crisis who can be adequately served in the community and by providing stabilizing services and supports to prevent crises from occurring.

In addition to issues relating to the State Hospitals, the Committee heard a report on downsizing at the State's Developmental Centers and found that the Centers have been unable to reduce the number of patients served. The General Assembly, in SL 2007-323, directed the State's Developmental Centers (the Caswell, Murdoch and Riddle centers) to reduce their number of residential patients and directed DHHS's budget to be reduced accordingly as the Centers censuses decreased. However, DHHS has informed the LOC that the Centers are not downsizing as expected, primarily because the patients living there are unable to be adequately and appropriately served in the community and due to increased demand from population increases. In order for the Centers to downsize effectively, consumers need supports for living, working, and participating in all aspects of community needs to be available. In addition to the direct supports, there also need to be affordable options for the actual residence.

North Carolina statutes on involuntary commitments of individuals to psychiatric facilities provide for transportation to the physician or eligible psychologist for the examination required by law. G.S. 122C-261, et seq. Questions have arisen regarding supervision of the individual during this time. Interpretations of current law, G.S. 122C-263(a), permit law enforcement officers who transport the individual to the appropriate facility to discontinue supervision of the individual once the officers have delivered the individual to the facility so long as there is adequate supervision at the facility. This situation raises issues of detention of an individual by the facility when the individual has neither been arrested nor committed to a State hospital by court order. Also involved is the question of using limited law enforcement resources to continue supervision of the individual pending the required examination.

---

[12] North Carolina Department of Health and Human Services, *State Plan 2001: Blueprint for Change, (November 31, 2001).*

## RECOMMENDATION TWO:

1. Due to the high use of adult admissions unit beds, appropriate $5,274,000 on a one-time basis and authorize the temporary opening of the Central Regional Hospital Wake Unit on the Dorothea Dix Campus.

2. Require that all deaths occurring in State institutions be reported to the State Medical Examiner to determine if further investigation into the cause of death and circumstances surrounding the death is necessary and appropriate the necessary funds of $155,226 to DHHS for an additional Public Health Nurse Consultant and other associated costs with the increased investigatory requirements.

   Direct the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services to study the current death reporting requirements established under G.S. §122C-26(5)(c) and assess the need for any additional reporting requirements or modifications to existing rules or procedures.

3. Appropriate $30 million to expand the Hospital Utilization Pilot statewide, in a manner that maintains local control of funds and of bed utilization, with a goal of reducing the use of State psychiatric hospital beds for those individuals staying 2 weeks or less.

4. Appropriate $1,134,168 to implement the Transitional Residential Treatment Program in each of the 3 psychiatric hospital catchment areas.

   Also, direct DHHS, in consultation with LMEs and providers, to develop and implement a plan for discharge planning at the local level for all disability groups to ensure that those individuals willing and able to transition to the community can successfully make that transition. Also direct DHHS to report to the General Assembly no later than January 1, 2009 on the actions taken.

5. Continue funding for the Housing 400 Initiative by appropriating $10 million to the Housing Trust Fund and $2.5 million to DHHS for recurring operating support for approximately 500 units. By providing stabilizing services and supports to prevent crises from occurring, appropriate housing will reduce the need for State Psychiatric hospitals in the long-term.

6. Provide for automatic re-enrollment in Medicaid for those individuals whose eligibility had been cancelled while in the hospital so that upon

their release they will have access through Medicaid to care and medications.

7. Direct DHHS, within current available resources, to implement the tiered CAP-MR/DD waiver program as directed in SL 2007-323, Section 10.49(dd). The Department shall implement the program with four tiers: (i) up to $10,000; (ii) between $10,001 and $25,000; (iii) between $25,001 and $75,000; and (iv) greater than $75,000.

8. Direct the Institute of Medicine (IOM) to study and report on the best practices in transition for persons with developmental disabilities from one life setting to another, including barriers to transition and best practices in successful transitions. The Institute of Medicine should conduct this study using funds appropriated for IOM studies in the 2007 Session, and the study should encompass at least the following topics: (i) the transition for adolescents leaving high school, including adolescents in foster care and those in other settings; (ii) the transition for persons with developmental disabilities who live with aging parents; and (iii) the transition from the developmental centers to other settings.

9. Direct DHHS to review State-County Special Assistance rates to establish an appropriate rate for special care units for persons with a mental health disability, including individuals with a Traumatic Brain Injury (TBI) and to review the rules pertaining to special care units for persons with a mental health disability to determine if additional standards are necessary.

10. Authorize a study of the pertinent commitment statutes, particularly G.S. 122C-263(a), to determine if an individual lawfully ordered to undergo an examination by a physician or eligible psychologist is being appropriately supervised during the period of the individual's examination.

11. Support DHHS's recommendation for additional funds for hiring and retention of proper staffing in the State Hospitals.

## FINDING THREE: SERVICES IN THE COMMUNITY

In March 2006, DHHS enacted new federally-approved "service definitions" for a variety of mental health services, including Community Support Services (CS). CS was designed to replace two former services (Community-Based Services and Case Management), and the State expected CS to cost approximately the same as what it replaced. However, in FY 2006-07, the service's State and Federal Medicaid cost was about $500 million higher than expected.

In the 2007 regular session, the General Assembly enacted Session Law 2007-323, of which Section 10.49(ee) implemented a number of changes to slow CS spending. DHHS also has taken steps to control the program's growth and expenses. But CS costs remain higher than anticipated in FY 2007-08, and spending is likely to exceed budget if it continues at the current rate.

The LOC believes that the overspending in the CS program has been caused by multiple factors, which are outlined below. It is the LOC's belief that not only have these factors caused the current problems with Community Support, but they leave the system vulnerable to similar problems in other MHDDSA areas.

**The CS Reimbursement Rate Encourages Low-Qualified Providers**
The State- and federally-approved CS definition allows for CS to be provided by paraprofessionals, associate professionals and qualified professionals – all of whom are reimbursed at the same rate. This "blended rate" has resulted in a rapid increase in the number of CS providers and in the service's costs, without administrative control over the necessity for the service, the type of service, and the qualifications of the service provider.

**Service Providers Have a Conflict of Interest In Performing Assessments**
Before receiving services or treatment, clients are evaluated and assessed to determine their diagnosis and treatment needs. However, these assessments are often conducted by a provider who also offers the services or treatments to which the client is referred. This creates a potential conflict of interest on the part of the provider and can lead to non-objective client assessments.

**DHHS Has Undercut the LMEs' Ability to Perform Statutory Core Functions**
LMEs core functions, as defined by General Statute 122C-115, include utilization management, utilization review, and determination of the appropriate level and intensity of services to ensure that services are needed and appropriately provided. However, the DHHS has transferred this function from LMEs to an

outside vendor for Medicaid-funded services. The outside vendor's performance of utilization review has been ineffective and inconsistent in its application, due in part to the absence of uniform review standards.

One function that has remained with the LMEs is provider endorsement. In order to provide Medicaid services, providers must first be endorsed by an LME as being qualified to provide the service. However, LMEs are not State agencies and have not been given sufficient authority to implement, monitor, and effectively enforce provider endorsement requirements in order to hold providers accountable. As a result, some endorsed providers are performing below standards required by State law and federal law.

Poor provider performance has given rise to concerns about the level, volume, and quality of services by providers, particularly with respect to community support services. In response to these concerns, LMEs have begun to deny, suspend, or refuse to renew provider endorsements; this has caused a spike in the number of provider appeals.

**The Appeals Process Should be Streamlined to Address a Substantial Backlog in Appeals Pending, and Should Be Simplified to Address Issues of Fairness**
The appeals process for Medicaid applicants and recipients needs to be streamlined, simplified, and balanced. Federal law requires a "fair hearing" when Medicaid services are reduced or denied and also requires resolution of the case within 90 days. Recent actions taken by the DHHS to reduce or eliminate services has caused a substantial increase in the volume of appeals, which in turn has caused a very large backlog of appeals pending. The result has created an increase in State Medicaid expenditures, case resolution far in excess of the time allowed under federal law, and a lawsuit recently filed raising due process issues. Last session the General Assembly provided for simplified appeals of Department of Revenue decisions by taxpayers, G.S. 105-241.15, and authorized the Chief Administrative Law Judge (OAH) to limit and simplify the procedures that apply to a contested tax case involving a taxpayer who is not represented by an attorney. G.S. 150B-31.1. A similar expedited process could be replicated for Medicaid contested cases. Changes to the appeals process to ensure that the interests of Medicaid clients are adequately represented may require additional funding to reduce the number of clients that appear pro se due to their financial situation.

**The Ability to Control the Provider Network Can Contribute to LME Success**
Piedmont Behavioral Health – the LME whose catchment area includes Davidson, Rowan, Cabarrus, Stanly and Union Counties – has a 1915 (b)/(c) combination Medicaid waiver that gives it flexibility in managing care. Among other features

the waiver allows Piedmont Behavioral Health (PBH) to control the size of its provider network. The LOC believes that this control has aided PBH's success.

## RECOMMENDATION THREE:

1. Require that DHHS develop and implement a tiered rate structure for community support services to replace the current "blended" rate. Under the new tiered structure, services that are necessary but do not require the skill, education, or knowledge of a qualified professional should not be paid at the same rate as services provided by qualified skilled professionals. Require DHHS to report to the LOC prior to implementing the new rate structure.

2. Require DHHS to develop and implement a service authorization process that separates the assessment function from the service delivery function. In doing so, the Department should consider as an option LME assessment centers whose duties would include care coordination. Require DHHS to report to the LOC prior to implementing the new service authorization process.

3. Direct DHHS to conduct a thorough study of the service authorization, utilization management, and utilization review processes and to develop a plan to return the service authorization, utilization review, and utilization management functions to LMEs for all clients.

   Direct DHHS to comply with the requirements of S.L. 2007-323, Section 10.49(ee). Prohibit DHHS from contracting with an outside vendor for service authorization, utilization review, or utilization management functions, or otherwise obligating the State for these functions beyond June 30, 2009. Direct DHHS to require LMEs to include in their service authorization, utilization management, and utilization review a review of assessments as well as person centered plans, and random or triggered audits of services and assessments.

   Also, require that the licensed professional who signs a medical order for services must indicate whether the licensed professional has (i) had contact with the consumer, and (ii) reviewed the consumer's assessment.

4. Direct DHHS to adopt guidelines for LME periodic review and re-endorsement of providers to ensure that only qualified providers are endorsed and that LMEs hold those providers accountable for the Medicaid and State-funded services they provide. Additionally, amend

state law to allow providers to appeal LME decisions on provider endorsements to the Office of Administrative Hearings.

5. Authorize the Office of Administrative Hearings (OAH) to develop a simplified procedure to streamline the process for hearing appeals of Medicaid recipients, applicants, and providers (including an automatic appeal for recipients and applicants). In developing the process the OAH should consult with DHHS to ensure that the streamlined and simplified process complies with federal "fair hearing" requirements. The process should be as simple and straightforward as possible, especially for appellants appearing without an attorney, without compromising the purpose of the Administrative Procedure Act, G.S. 150B-2, et seq., and allowing for a complete record of the hearing to be maintained by the presiding administrative law judge.

   Also, require DHHS, in its written notice of the reduction, termination, or denial of services, to provide information clearly explaining the opportunities for appeal and the reasons for the decision.

6. Direct DHHS to study Medicaid waivers, including 1915(b) and (c) waivers, for all LMEs or some other mechanism to allow LMEs to the ability to provide case management, assessment, or other management functions and to limit provider networks. Recognizing that waivers may not be appropriate for all LMEs, direct the Department to study what would be needed to increase LMEs flexibility for innovation.

7. Direct DHHS to develop a plan for General Assembly review that would merge, consolidate, or provide for regional arrangements or consortia with respect to LME structure. The Secretary should consult with LMEs in the development of the plan and should submit the plan to the General Assembly for review. Further, require that the Secretary take no action to merge, consolidate, or provide for regional arrangements or consortia with respect to LME structure before January 1, 2010.

8. Support the recommendation of the *MH/DD/SAS Workforce Plan* to appropriate the necessary funds to DHHS to establish a Workforce Development Specialist position within the Division of MH/DD/SAS. This specialist should have expertise in assessing workforce issues and will serve as the project manager for implementing the Division's workforce development initiatives, particularly the recommendations identified in the *MH/DD/SAS Workforce Plan*.

# APPENDIX

**Copies of the proposed legislation begin on the following page.**

**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 2007**

**H/S** **D**

**BILL DRAFT 2007-LNz-309A* [v.10] (4/2)**

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)**
**4/30/2008 1:18:42 PM**

| | |
|---|---|
| Short Title: | Recommendations of MH/DD/SA Oversight Comm. (Public) |
| Sponsors: | |
| Referred to: | |

A BILL TO BE ENTITLED

AN ACT TO ENACT VARIOUS LAWS TO IMPROVE THE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES SYSTEM, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

**SECTION 1.1. Expenditure of Service Dollars.** - For the purpose of mitigating cash-flow problems that many non-single-stream LMEs experience at the beginning of each fiscal year, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall adjust the timing and method by which allocations of service dollars are distributed to each non-single-stream LME. To this end, the allocations shall be adjusted such that at the beginning of the fiscal year, the Department shall distribute not less than one-twelfth of the LME's continuation allocation and subtract the amount of the adjusted distribution from the LME's total reimbursements for the fiscal year.

**SECTION 1.2.** There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of six million dollars ($6,000,000) for the 2008-2009 fiscal year. These funds shall be used to support LMEs in establishing additional regionally-purchased and locally-hosted substance abuse programs. Funds appropriated shall be for the purpose of developing and enhancing the American Society of Addiction Medicine (ASAM) continuum of care at the community level. The Department of Health and Human Services shall work with LMEs in establishing these programs.

**SECTION 1.3.(a)** There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental

Disabilities, and Substance Abuse Services, the sum of six hundred seventy-five thousand dollars ($675,000) for the 2008-2009 fiscal year. These funds shall be used to contract with an outside vendor for technical assistance to LMEs that are not meeting the standards necessary for single-stream funding.

**SECTION 1.3.(b)** The Department shall encourage the conversion of the remaining non-single-stream LMEs to single-stream funding as soon as possible. The Department shall also develop standards for the removal of single-stream designation for those LMEs that do not continue to comply with the applicable requirements for single-stream funding.

**SECTION 1.4.** The Department of Health and Human Services shall simplify the current State Integrated Payment and Reporting System (IPRS) to encourage more providers to serve State-paid clients.

**SECTION 1.5.** The Department of Health and Human Services shall create a reporting system for both single-stream funding and non-unit-cost reimbursement funding that is readily comprehensible and integrates with payment systems.

**SECTION 1.6.** The Department of Health and Human Services shall determine why there have been under- and over-expenditure of State service dollars by LMEs and shall take the action necessary to address the problem. In making its determination the Department shall consult with LMEs and providers. Not later than January 1, 2009, the Department shall report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Fiscal Research Division and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on actions taken to address problem of LME under- and over-expenditure of service dollars.

**SECTION 1.7.(a)** There is appropriated from the General Fund to the General Assembly the sum of one million dollars ($1,000,000) for the 2008-2009 fiscal year. These funds shall be used to retain the services of an independent consultant to perform a services gap analysis of the Mental Health, Developmental Disabilities, and Substance Abuse Services System. In developing the RFP the Fiscal Research Division shall require the Independent Consultant to report on or before May 1, 2009 its findings and recommendations to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division.

**SECTION 1.7.(b)** In developing its work plan, the Joint Legislative Program Evaluation Oversight Committee may include a thorough performance evaluation of the State's mental health agencies in the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Division of Medical Assistance. The performance evaluation shall be completed not later than May 1, 2009.

**SECTION 2.1.(a). State-Operated Services.** – In order to temporarily address high admissions to adult acute unit beds in the State psychiatric hospitals, the Secretary of the Department of Health and Human Services may open and operate on a temporary basis the Central Regional Hospital Wake Unit on the Dorothea Dix Campus and may maintain the Wake Unit on the Dix Campus until beds become available in the system.

**SECTION 2.1.(b).** G.S. 122C-181(a)(1) reads as rewritten:

**"§ 122C-181. Secretary's jurisdiction over State facilities.**

(a) Except as provided in subsection (b) of this section, the Secretary shall operate the following facilities:

(1) Psychiatric Hospitals:

a. Cherry Hospital.

a1. **(Contingent effective date, see Editor's note)** Central Regional Hospital.

b. **(Contingent repeal date, see Editor's note)** Dorothea Dix Hospital.

c. **(Contingent repeal date, see Editor's note)** John Umstead Hospital.

d. Broughton Hospital.

e. The Central Regional Hospital Wake Unit on the Dorothea Dix Campus."

This subsection expires upon the earlier of July 1, 2009 or the availability of beds at Central Regional Hospital.

**SECTION 2.1.(c)** There is appropriated from the General Fund to the Department of Health and Human Services the sum of five million two hundred seventy-four thousand dollars ($5,274,000) for the 2008-2009 fiscal year. These one-time funds shall be used to support the temporary opening and operation of the Central Regional Hospital Wake Unit on the Dorothea Dix Campus.

**SECTION 2.2.(a)** G.S. 130A-383(a) reads as rewritten:

**"§ 130A-383. Medical examiner jurisdiction.**

(a) Upon the death of any person resulting from violence, poisoning, accident, suicide or homicide; occurring suddenly when the deceased had been in apparent good health or when unattended by a physician; occurring in a jail, prison, correctional ~~institution~~ institution, State facilities operated in accordance with Part 5 of Article 4 of Chapter 122C of the General Statutes; or in police custody; occurring pursuant to Article 19 of Chapter 15 of the General Statutes; or occurring under any suspicious, unusual or unnatural circumstance, the medical examiner of the county in which the body of the deceased is found shall be notified by a physician in attendance, hospital employee, law-enforcement officer, funeral home employee, emergency medical technician, relative or by any other person having suspicion of such a death. No person shall disturb the body at the scene of such a death until authorized by the medical examiner unless in the unavailability of the medical examiner it is determined by the appropriate law enforcement agency that the presence of the body at the scene would risk the integrity of the body or provide a hazard to the safety of others. For the limited

purposes of this Part, expression of opinion that death has occurred may be made by a nurse, an emergency medical technician or any other competent person in the absence of a physician."

**SECTION 2.2.(b)** G.S. 122C-31 is amended by adding the following new subsection to read:

**"§ 122C-31. Report required upon death of client.**

"…

"(g) In addition to the reporting requirements specified in subsections (a) through (e) of this section, and pursuant to G.S. 130A-383, every State facility shall report the death of any client of the facility, regardless of the manner of death, to the medical examiner of the county in which the body of the deceased is found."

**SECTION 2.2.(c)** There is appropriated from the General Fund to the Department of Health and Human Services, the sum of one hundred fifty-five thousand two hundred twenty-six dollars ($155,226) for the 2008-2009 fiscal year. These funds shall be used for one additional public health nurse consultant position and other costs associated with the increased investigatory requirements of this section.

**SECTION 2.2.(d)** The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall study the current death reporting requirements under G.S. 122C-26(5)(c) and assess the need for any additional reporting requirements or modifications to existing rules or procedures. The Commission shall report its findings to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services not later than November 1, 2008.

**SECTION 2.3.** There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of thirty million dollars ($30,000,000) for the 2008-2009 fiscal year. These funds shall be used to expand the Hospital Utilization Pilot Program statewide in a manner that maintains local control of funds and bed allocations, with a goal of reducing the use of State psychiatric hospital beds for those individuals staying two weeks or less.

**SECTION 2.4.(a)** There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of one million one hundred thirty-four thousand one hundred sixty-eight dollars ($1,134,168) for the 2008-2009 fiscal year to implement three pilot programs of the Transitional Residential Treatment Program. One pilot program shall be located in each of the State's three State psychiatric hospital catchment areas.

**SECTION 2.4.(b)** The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall develop and implement a plan for discharge planning at the local level for all disability groups. The Department shall implement its plan as soon as possible.

**SECTION 2.5.(a)** There is appropriated from the General Fund to the Housing Trust Fund the sum of ten million dollars ($10,000,000) for the 2008-2009

fiscal year for the Housing 400 Initiative in order to reduce the need for State psychiatric hospitals in the long-term.

**SECTION 2.5.(b)** There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of two million five hundred thousand dollars ($2,500,000) for the 2008-2009 fiscal year to continue operating support for an estimated 500 units of the Housing 400 Initiative in order to reduce the need for State psychiatric hospitals in the long-term. It is the intent of the General Assembly that these funds shall be appropriated on a recurring basis.

**SECTION 2.6.** Not later than October 1, 2008, the Department of Health and Human Services, Division of Medical Assistance, shall provide for automatic re-enrollment of Medicaid recipients whose Medicaid eligibility had been cancelled because of admission to the hospital. The purpose of automatic re-enrollment is to ensure that upon release from the hospital the eligible Medicaid recipient will have uninterrupted access to care and medications under the Medicaid program.

**SECTION 2.7.** The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall, within available resources, implement the tiered CAP-MR/DD waiver program in accordance with Section 10.49(dd) of S.L. 2007-323. The Department shall implement the program with four tiers: (i) up to $10,000; (ii) between $10,001 and $25,000; (iii) between $25,001 and 75,000; and (iv) greater than $75,000.

**SECTION 2.8.** The North Carolina Institute of Medicine shall study and report on the transition for persons with developmental disabilities from one life setting to another, including barriers to transition and best practices in successful transitions. The IOM should conduct this study using funds appropriated for IOM studies in the 2007 Session. The study should encompass at least the following topics: (i) the transition for adolescents leaving high school, including adolescents in foster care and those in other settings; (ii) the transition for persons with developmental disabilities who live with aging parents; and (iii) the transition from the developmental centers to other settings.

**SECTION 2.9.** The Department of Health and Human Services shall review State-County Special Assistance rates to establish an appropriate rate for special care units for persons with a mental health disability, including individuals with Traumatic Brain Injury (TBI), and shall review current rules pertaining to special care units for persons with a mental health disability to determine if additional standards are necessary. Effective July 1, 2008, care provided to individuals with Traumatic Brain Injury shall be paid at the special care unit rate paid for care of persons with a mental health disability. The Department shall report its findings and recommendations to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division not later than January 1, 2009.

**SECTION 3.1 Community Services.** - In order to ensure accountability for services provided and funds expended for community services, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall develop a tiered rate structure to replace the blended rate currently used for community support services. Under the new tiered structure, services that are necessary but do not require the skill, education, or knowledge of a qualified professional should not be paid at the same rate as services provided by qualified skilled professionals. The Department shall report on the development of the structure to the Joint Legislative Oversight Committee (LOC) on Mental Health, Developmental Disabilities, and Substance Abuse Services not later than October 1, 2008. The Department shall not implement the tiered rate structure until after it has consulted with the LOC.

**SECTION 3.2.** The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall develop a service authorization process that separates the assessment function from the service delivery function at the LME level. In developing the process the Department shall consider as an option separate LME assessment centers, the duties of which would include care coordination. The Department shall report on the development of the service authorization process to the Joint Legislative Oversight Committee (LOC) on Mental Health, Developmental Disabilities, and Substance Abuse Services not later than October 1, 2008. The Department shall not implement the service authorization process until after it has consulted with the LOC.

**SECTION 3.3.(a).** The Department of Health and Human Services shall conduct a thorough study of the service authorization, utilization review, and utilization management processes and shall develop a plan to return the service authorization, utilization review and utilization management functions to LMEs for all clients. Not later than February 1, 2009, the Department shall report its findings and recommendations to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the fiscal research division. The Department shall comply with the requirements of S.L. 2007-323, Section 10.49(ee). The Department shall not contract with an outside vendor for service authorization, utilization review, or utilization management functions, or otherwise obligate the State for these functions beyond June 30, 2009. The Department shall require LMEs to include in their service authorization, utilization management, and utilization review a review of assessments as well as person centered plans, and random or triggered audits of services and assessments.

**SECTION 3.3.(b).** The Department shall require that the licensed professional that signs a medical order for behavioral health services must indicate on the order whether the licensed professional has (i) had direct contact with the consumer, and (ii) has reviewed the consumer's assessment. This requirement shall take effect no later than October 1, 2008.

**SECTION 3.4.(a)** G.S. 122C-151.4reads as rewritten:

"**§ 122C-151.4. Appeal to State MH/DD/SA Appeals Panel.**

(a) Definitions. – The following definitions apply in this section:

(1) "Appeals Panel" means the State MH/DD/SA Appeals Panel established under this section.

(1a) "Client" means an individual who is admitted to or receiving public services from an area facility. "Client" includes the client's personal representative or designee.

(1b) "Contract" means a contract with an area authority or county program to provide services, other than personal services, to clients and other recipients of services.

(2) "Contractor" means a person who has a contract or who had a contract during the current fiscal ~~year.~~ year, or whose application for endorsement has been denied by an area authority or county program.

(3) "Former contractor" means a person who had a contract during the previous fiscal year.

(b) Appeals Panel. – The State MH/DD/SA Appeals Panel is established. The Panel shall consist of three members appointed by the Secretary. The Secretary shall determine the qualifications of the Panel members. Panel members serve at the pleasure of the Secretary.

(c) Who Can Appeal. – The following persons may appeal to the State MH/DD/SA Appeals Panel after having exhausted the appeals process at the appropriate area authority or county program:

(1) A contractor or a former contractor who claims that an area authority or county program is not acting or has not acted within applicable State law or rules in denying the contractor's application for endorsement or in imposing a particular requirement on the contractor on fulfillment of the contract;

(2) A contractor or a former contractor who claims that a requirement of the contract substantially compromises the ability of the contractor to fulfill the contract;

(3) A contractor or former contractor who claims that an area authority or county program has acted arbitrarily and capriciously in reducing funding for the type of services provided or formerly provided by the contractor or former contractor;

(4) A client or a person who was a client in the previous fiscal year, who claims that an area authority or county program has acted arbitrarily and capriciously in reducing funding for the type of services provided or formerly provided to the client directly by the area authority or county program; and

(5) A person who claims that an area authority or county program did not comply with a State law or a rule adopted by the Secretary or the Commission in developing the plans and budgets of the area authority or county program and that the failure to comply has adversely

affected the ability of the person to participate in the development of the plans and budgets.

(d) Hearing. – All members of the State MH/DD/SA Appeals Panel shall hear an appeal to the Panel. An appeal shall be filed with the Panel within the time required by the Secretary and shall be heard by the Panel within the time required by the Secretary. A hearing shall be conducted at the place determined in accordance with the rules adopted by the Secretary. A hearing before the Panel shall be informal; no sworn testimony shall be taken and the rules of evidence do not apply. The person who appeals to the Panel has the burden of proof. The Panel shall not stay a decision of an area authority during an appeal to the Panel.

(e) Decision. – The State MH/DD/SA Appeals Panel shall make a written decision on each appeal to the Panel within the time set by the Secretary. A decision may direct a contractor, an area authority, or a county program to take an action or to refrain from taking an action, but it shall not require a party to the appeal to pay any amount except payment due under the contract. In making a decision, the Panel shall determine the course of action that best protects or benefits the clients of the area authority or county program. If a party to an appeal fails to comply with a decision of the Panel and the Secretary determines that the failure deprives clients of the area authority or county program of a type of needed service, the Secretary may use funds previously allocated to the area authority or county program to provide the service.

(f) Chapter 150B Appeal. – A person who is dissatisfied with a decision of the Panel may commence a contested case under Article 3 of Chapter 150B of the General Statutes. Notwithstanding G.S. 150B-2(1a), an area authority or county program is considered an agency for purposes of the limited appeal authorized by this section. If the need to first appeal to the State MH/DD/SA Appeals Panel is waived by the Secretary, a contractor may appeal directly to the Office of Administrative Hearings after having exhausted the appeals process at the appropriate area authority or county program. The Secretary shall make a final decision in the contested case."

**SECTION 3.4.(c)** The Department of Health and Human Services shall adopt guidelines for LME periodic review and re-endorsement of providers to ensure that only qualified providers are endorsed and that LMEs hold those providers accountable for the Medicaid and State-funded services they provide.

**SECTION 3.5.(a)** Effective October 1, 2008, the Title of G.S. 108A-79 reads as rewritten:

"**§ 108A-79. ~~Appeals.~~Appeals of county level decisions.**"

**SECTION 3.5.(b).** Effective October 1, 2008, Article 4 of Chapter 108A of the General Statutes is amended by adding the following new section to read:

"**§ 108A-79.1. Appeals by Medicaid applicants and recipients.**

(a) An action by the Department to deny, terminate, suspend, or reduce Medicaid eligibility, or to deny, terminate, suspend, or reduce Medicaid services is a "contested case" subject to the provisions of Chapter 150B of the General Statutes, except as provided by this section. At the time of providing the notice required under subsection (b) of this section, the Department shall file a petition with the Office of Administrative Hearings to determine the Medicaid applicant's or recipient's rights duties or privileges.

(b) In addition to the notice requirements of G.S. 150B-23, the Department shall provide within 30 days of its decision written notice to the aggrieved applicant or recipient, or the applicant's or recipient's legal guardian, which notice shall include:

(1) An explanation of the Department's decision.

(2) A clear and concise statement of what service is being reduced, terminated, or denied and the basis upon which the decision was made.

(3) A statement that the Department has filed a petition for administrative review of its decision in the Office of Administrative Hearings, and that the applicant or recipient has 30 days from the date of the Department's decision to decide whether or not to proceed with the hearing.

(4) A clear explanation of how the hearing will proceed, what is required of the applicant in order to proceed or to decline to proceed, and that the applicant or recipient may be represented by an attorney or other person at the hearing. The notice shall further state that representation by an attorney may be available from Disability Rights of NC legal services, and attorneys working with mediation centers throughout the State.

(5) A statement that the recipient will continue to receive Medicaid services at the level provided on the day immediately preceding the Department's decision pending a final decision.

(6) The telephone number of a contact person at the Department to respond in a timely fashion to applicant or recipient questions.

(7) A brochure supplied by the North Carolina Protection and Advocacy System that explains the rights of applicants and recipients under the State Medical Assistance Program, including the rights to appeal decisions of the Department."

**SECTION 3.6.** The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall study Medicaid waivers, including 1915(b) and (c) waivers, for all LMEs. In cases where Medicaid waivers are not appropriate for an LME, the Department shall identify and recommend strategies to increase LME flexibility to provide case management, assessment, limit provider networks, or other innovative approach for managing care. Not later than March 1, 2009, the Department shall report its findings and recommendations to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the fiscal research division.

**SECTION 3.7.(a)** The Secretary of the Department of Health and Human Services shall develop a detailed plan for General Assembly review on its recommendation to merge, consolidate or establish regional arrangements or consortia of LMEs. In developing the plan the Secretary shall consult with LMEs to obtain input on the feasibility and effectiveness of potential mergers, and the time frame needed to

fully implement the mergers, regional arrangements, or consortia at the local level. The Secretary shall provide the plan to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division not later than March 1, 2009.

**SECTION 3.7.(b)** The Secretary of the Department of Health and Human Services shall not take any action prior to January 1, 2010 that would result in the merger or consolidation of LMEs operating on January 1, 2008 or that would establish consortia or regional arrangements for the same purpose, except that LMEs that do not meet the catchment area requirements of G.S. 122C-115 as of January 1, 2008, may initiate, continue, or implement the LMEs' merger or consolidation plans to overcome noncompliance with G.S. 122C-115.

**SECTION 4. Effective date.** - This act becomes effective July 1, 2008.

**GENERAL ASSEMBLY OF NORTH CAROLINA**

**SESSION 2007**

**H** **D**

**BILL DRAFT 2007-LNz-313 [v.4] (4/16)**

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)**
**4/24/2008 11:33:16 AM**

| |
|---|
| Sponsors: |
| Referred to: |

A JOINT RESOLUTION TO AUTHORIZE THE LEGISLATIVE RESEARCH COMMISSION TO STUDY CERTAIN MENTAL HEALTH COMMITMENT STATUTES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

Be it resolved by the House of Representatives, the Senate concurring:

**SECTION 1.(a)** The Legislative Research Commission may study the involuntary commitment statutes in Chapter 122C of the General Statutes, in particular G.S. 122C-263(a), to determine if an individual lawfully ordered to undergo an examination by a physician or eligible psychologist is being appropriately supervised to protect the health and safety of the individual and others during the period of the individual's examination.

**SECTION 1.(b)** The Legislative Research Commission may make an interim report to the 2008 General Assembly, and shall make its final report to the 2009 General Assembly.

**SECTION 2.** The Legislative Services Officer shall allocate funds appropriated to the General Assembly for the expenditures of the Legislative Services Commission in conducting this study.

**SECTION 3.** This resolution is effective upon ratification.